July 23, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1309-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is a board certified anesthesiologist. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 33 year-old female who sustained a work related injury on ___. The patient reported that while at work she was picking up bolts and lights in a box when she began to experience a burning sensation across her back. The patient was initially treated with medications and physical therapy. The patient experienced an exacerbation in February of 2002 and was then treated with lumbar epidural steroid injections. The patient underwent an MRI 4/22/02 that showed a small left posterolateral disc protrusion at L5-S1 projecting into the left neuroforamin with direct contact to the left S1 nerve root. The patient underwent an NCV test on 4/29/02 and an EMG 5/8/02. The patient participated in a work hardening program.

Requested Services

Purchase of interferential muscle stimulator.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 33 year-old female who sustained a work related injury to her low back on ___. The ___ physician reviewer also noted that the patient underwent an MRI of the lumbar spine that showed a small left posterolateral disc protrusion at L5-S1 projecting into the left neural foramen with direct contact of the disc protrusion to the left S1 nerve root. The ___ physician reviewer indicated that a nerve conduction study in 5/02 demnostrated evidence of an acute L5 and S1 motor radiculopathy consistent with the disc protrusion noted on the imaging study. The ___ physician reviewer indicated that a chiropractor and pain management specialist has treated the patient. The ___ physician reviewer noted that the treatment included manipulation therapy and epidural steroid injection therapy without sustained pain relief. The ___ physician reviewer also noted that the patient completed a work hardening program and continued to complain of low back pain. The ___ physician reviewer indicated that the pain consultant recommended a trial use of a muscle stimulator. The ___ physician reviewer noted that the patient reported a decrease of pain and increased her function. However, the ___ physician reviewer explained that there is no documentation supporting the long term efficacy of treatment with a muscle stimulator. The ___ physician reviewer also explained that the patient has not undergone a neurosurgical evaluation to determine if she is a surgical candidate. Therefore, the ___ physician consultant concluded that the requested purchase of the interferential muscle stimulator is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 23rd day of July 2003.